

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 24 1948

U.S. DEPARTMENT OF HEALTH STANDARD CERTIFICATE OF DEATH

38421
State File No. _____
Registrar's No. 9684

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
In this community 7 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

EVA MAIDEN

3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Joseph
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased July 10, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 3 24 hr. min. 0

9. Birthplace Lathrop Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business _____

12. Name Frank Frisbie
13. Birthplace Missouri
14. Maiden name Mary Brown
15. Birthplace Oklahoma
(City, town, or county) (State or foreign country)

16. (a) Informant Christine Montague
(b) Address 2652 Austin, Detroit, Mich
17. (a) burial (b) Date thereof 11-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) NOV 8 1948 (b) J. B. Laster
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2634 Caroline Street
Memorial (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th
year 1948 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10/22/48
_____, 19____, to 11/4/48, 19____;
that I last saw h. er alive on 11/4/48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Vascular
accident

Due to _____

Due to _____

Other conditions
(Include pregnancy within 9 months of death)

Cellulitis Left leg

Major findings:
Of operations _____

Of autopsy Same

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature E. J. Cason 11/4/48 (other) _____
Address 1515 Lafayette Date signed _____

96896

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed L R Cooper

Licensed Embalmer No. 3633

P. O. Address 5301 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.